

THE DIVISION OF HEALTH OF MISSOURI 37434-58
STANDARD CERTIFICATE OF DEATH

58-028330
STATE FILE NUMBER

42 Primary Registration District No. 1000 Registrar's No. 894
FILED AUG 25 1958 Registration District No.

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1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.		Length of stay in lb Life	8. STREET ADDRESS (If outside, give location) 1720 S. 6th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FREDDIE CONTY STONE			4. DATE OF DEATH Month Day Year August 14, 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1958		9. AGE (In years last birthday) Months Days Hours Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Not Given		13b. MOTHER'S MAIDEN NAME Corine Stone		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Corine Stone 1720 S 6th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia				INTERVAL BETWEEN ONSET AND DEATH 24 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Dehydration				24 hours	
DUE TO (c) Pneumonia				24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8-12-58 to 8-14-58 and last saw him alive on 8-14-58 Death occurred at 11 p.m. 8-14-58 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Wm. B. Roach			22b. ADDRESS 316 North St Joseph Mo		22c. DATE SIGNED 8-18-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 16, 1958	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Beatrice Gray		ADDRESS D 812 Pacific St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Aug 21, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Stodell

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John T. Miles*
Licensed Embalmer No. *3446*
P. O. Address *Atchison*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.